Vygart

(efgartigimod alfa-fcab)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____ lbs or_____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- EMG Confirming MG
- MG-ADL Assessment
- Tried and Failed Therapies (including duration)

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Vyvgart
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Vyvgart 10mg/kg (fixed dose _____mg not to exceed 1200mg) IV once weekly x4 doses

Provider to determine frequency of cycles. Check ONE:

☐ One cycle only. (Provider to submit new referral when due for following cycle.)
☐ Repeat cycle every 28 days from last dose for 6 total cycles for one full year
☐ Repeat cycle every 28 days from last dose for _____total cycles

☐ Other: _____

Regardless of frequency, authorization will be obtained for 6 cycles (1 full year).
If a treatment is delayed by more than 3 days, then the current cycle will be restarted.

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists ' protocol (See infusionspecialists.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

VYEPTI
(eptinezumab-jjmr)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- History & Physical

- # of Headache Days in Last Month:_____
- # of Migraine Days in Last Month:_____

PRIMARY DIAGNOSIS

☐ G43.009 Migraine w/o aura, not intractable, w/o status migrainosus
☐ G43.709 Chronic migraine w/o aura, not intractable, w/o status migrainosus
☐ G43.711 Chronic migraine w/o aura, intractable, with status migrainosus
☐ G43.719 Chronic migraine w/o aura, intractable, w/o status migrainosus
☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Vyepti
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Vyepti 100mg IV every 3 months
☐ Vyepti 300mg IV every 3 months
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date